

# WORKERS' COMPENSATION AGENCY COMPENSABILITY RECOMMENDATION

Employee Name	Date of Injury
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**ENCLOSURES:** (Check Where Applicable)

- ☐ Employer's First Report of Occupational Injury or Disease (required enclosure)
- ☐ Supervisor's Report of Employee's Injury
- ☐ Employee's Report of Injury
- ☐ Wage Statement
- ☐ Schedule of Dependent(s) and Filing Status Statement
- ☐ Limited Certificate Authorizing Written Release of Medical/Health Care Information

☐ **ACCEPT**      ☐ **ACCEPT PENDING INVESTIGATION**      ☐ **DENIAL**

PRIMARY REASON FOR DENIAL	PAYMENT INFORMATION	
<b>(Check Only One)</b> <input type="checkbox"/> legal causation/compensability <input type="checkbox"/> medical treatment/bill review <input type="checkbox"/> benefits amount in dispute <input type="checkbox"/> jurisdiction <input type="checkbox"/> extent of incapacity <input type="checkbox"/> notice <input type="checkbox"/> statute of limitation <input type="checkbox"/> coverage	<b>Indemnity (Check Only One)</b> <input type="checkbox"/> being paid <input type="checkbox"/> in dispute <input type="checkbox"/> disputed but paid without prejudice <input type="checkbox"/> not applicable at time of filing	<b>Medical (Check Only One)</b> <input type="checkbox"/> being paid <input type="checkbox"/> in dispute <input type="checkbox"/> specific treatment in dispute <input type="checkbox"/> not applicable at time of filing
<b>Explanation:</b>		
<b>Person Filing Report</b> <b>Department</b>		
<b>Title:</b> <b>Date:</b> <b>Telephone:</b>		

Please attach (as the cover) to all Employer's First Reports submitted to:  
Workers' Compensation Division  
114 State House Station  
220 Capitol Street  
Augusta, ME 04333-0114

The only form that is required to be submitted with the "Agency Compensability Recommendation" form is the "Employer's First Report of Occupational Injury or Disease". Do not hold up submission for any other form.